

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38408
STATE FILE NUMBER
Registration District No. 317 Primary Registration District No. 531 Registrar's No. 2632

FILED NOV 15 1957

S. 300
P. 1-57

| | | | | | |
|---|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>University City</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>University City</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6412 ENRIGHT AVE.</u> | | Length of stay in lb <u>5 YEARS</u> | d. STREET ADDRESS <u>6412 Enright Ave.</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>NMN</u> Last <u>BOCKNER</u> | | | 4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>22</u> Year <u>1957</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept. 12, 1923</u> | 9. AGE (In years by birthday) <u>34</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Social-Worker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Social Organ.</u> | 11. BIRTHPLACE (City and state or country) <u>Toronto Ontario CANADA</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Sam Bockner</u> | | 13b. MOTHER'S MAIDEN NAME <u>Rebecca Freifeld</u> | | 14. NAME OF HUSBAND OR WIFE <u>Phyllis Bockner</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>UNK.</u> | | 16. SOCIAL SECURITY NO. <u>Unk.</u> | 17. INFORMANT Address <u>Mrs. Phyllis Bockner 6412 Enright Ave.</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HODGKIN'S DISEASE</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 YEARS</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u>201 X</u> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>TERMINAL BRONCHIAL PNEUMONIA 3 DAYS</u> | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u> </u> | | | |
| 20c. TIME OF INJURY Hour <u> </u> Month, Day, Year a.m. <u> </u> p.m. <u> </u> | | | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE <u> </u> | |
| 21. I attended the deceased from <u>APRIL 4, 1955</u> to <u>OCT. 22, 1957</u> and last saw her/him alive on <u>OCT. 22, 1957</u> Death occurred at <u>9:25 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Edmond J. Reinhard M. D.</u> | | | 22b. ADDRESS <u>4960 Audubon St. Louis (10)</u> | | 22c. DATE SIGNED <u>10-23-57</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>10/24/57</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>St. Louis County Missouri</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Herman Rindskopf Inc. 5216 Delmar</u> | | | 25. DATE RECD. BY LOCAL REG. <u>10-23-57</u> | 26. REGISTRAR'S SIGNATURE <u>Herbert R. Amick</u> | |

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY Y-BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

01001.0

Present

01001.00

your representative

your representative

ev. the first 5140

signed

of (S) (S) (S) (S)

signed

NAME OF THE EMBALMER

NAME OF THE EMBALMER

working under my personal supervision

working under my personal supervision

ev. the first 5140 request

ev. the first 5140

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *[Handwritten Signature]*

Licensed Embalmer No. *3691*

P. O. Address *[Handwritten Address]*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting. If this body is not embalmed, fact should be so stated above.